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GUERSANT ON SURGICAL DISEASES OF INFANTS, ETC., 16 PAGES.

CLINICS.

CLINICAL LECTURES.

Clinical Lecture on the Treatment of Hæmoptysis. By A. T. H. WATERS, M.D., Physician to the Liverpool Northern Hospital.

GENTLEMEN: I wish to call your attention to the treatment of hæmoptysis. Cases of this affection are very frequently met with in our wards, and will often occur to you in your practice hereafter. There is scarcely any symptom which more alarms the patient, or a patient's friends, than the expectoration of blood; for people have a well-founded belief that it is a very common indication of the existence of pulmonary consumption. Indeed, setting aside those cases in which hæmoptysis is associated with heart-disease, or is of a vicarious character, in a very large proportion of the remainder it is undoubtedly connected with phthisis. I do not mean to say that hæmoptysis always indicates the presence of tubercles in the lungs, for I believe it may occur at a very early period of consumption, and before any tuberculous deposit has taken place—in fact, that, at times, it is the first indication of phthisis, and may determine the development of that disease. The existence of hæmoptysis cannot prove to you that pulmonary consumption has arrived at any particular stage; for just as, I believe, it may take place before there is any tuberculous deposit, so it may occur when the disease is far advanced, and the lung full of cavities.

Considering the frequency of hæmoptysis, it is only in a small proportion of cases that it proves fatal—the patient dying suddenly from the profuseness o

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the hemorrhage, and consequent suffocation, or sinking more or less rapidly from exhaustion. A case of rapid sinking occurred not long ago in my practice in the hospital, and I will briefly relate it to you.

H. G., aged 30, was admitted under my care on October 12th, 1869. He was brought from a vessel which had just arrived in the port, and was spitting up large quantities of blood. He was in a sinking state when admitted, and he died in about six hours. He had been under my care in the hospital three months previously. At that time there was dulness, with other signs of consolidation at the base of the left lung, and I considered the case to be either chronic pneumonia, likely to develop into phthisis, or phthisis beginning at the base. On making a *post-mortem* examination, we found a large cavity at the base of the left lung, and a smaller one at the apex, and the substance of the lung was studded throughout with tubercles. The anterior part of the lung was emphysematous, and also contained tubercles. The right lung was more or less emphysematous throughout, and infiltrated with tubercles. In the middle lobe there was a large cavity filled with blood. A considerable quantity of blood was also found in the stomach. Here, then, we had a case in which ulceration or rupture of a large vessel on the walls of a cavity produced hemorrhage so profuse as to cause rapid death.

This is the only case that has occurred in my practice in this hospital where hæmoptysis has been *directly* fatal; but, curiously enough, within a short time—about ten days—of the death of my patient, my colleague, Dr. Glynn, lost a patient from pulmonary hemorrhage, and, after death, a cavity was found in the left lung, into which blood had been poured in large quantity.

Whenever hæmoptysis is only slight, during the progress of a case of phthisis, no special treatment need be directed to it. It is better to continue the measures which you are adopting for the general treatment of the disease, and give encouragement to your patient if he be disposed to be alarmed at the appearance of a few specks of blood. But should the hemorrhage be at all severe, you should at once enjoin rest, nor should you allow your patient to take exercise, or run any risk, by which an inflammatory attack might be brought on, until all appearances of blood have been lost for some days. I consider this rest and care most important, whether there have been no previous symptoms of phthisis and no other signs are present, or whether you have indications of existing deposit; and for this reason: that hæmoptysis is not unfrequently followed by pneumonia, especially where the hemorrhage has been severe. When blood is poured out into the lungs, unless it be all expectorated, it must necessarily act as an irritant, and inflammation is liable to set up around it. This inflammation is often of a limited character; but, in two instances which have occurred to me within a somewhat recent period, extensive pneumonia followed hæmoptysis. It is true that in both these cases the hemorrhage was copious, and in one which I shall relate to you a very large quantity of blood was lost.

I would caution you, therefore, to be on your guard, in all cases where hæmoptysis is at all severe, against the occurrence of pneumonia. It is better, I think, to err on the side of keeping the patient quiet, than to allow him to incur risk by too early exercise or exposure. The pneumonia which may result from pulmonary hemorrhage may determine the development of phthisis, which might possibly, by the exercise of proper care, have been prevented from becoming developed.

There is a kind of hæmoptysis which I have met with which is, I believe, the result of a simple oozing of blood from the mucous membrane of the bronchial tubes. The blood is not mixed with viscid sputa, nor is it pure blood; but the expectoration has very much the appearance of currant-juice. I have lately had a patient in whom this kind of expectoration had existed for a considerable time, and in whom, at the time he first came to me, I could discover no physical signs of consolidation of either lung. He had taken various medicines for the hemorrhage, but nothing had done much good. I did not for some time adopt any special treatment for the

bleeding, but confined myself to the administration of tonics, quinia, iron, and cod-liver oil. But, finding that the symptom did not cease, I ordered gallic acid in ten-grain doses three times a day. This had the desired effect, and soon the hemorrhage stopped. It has recurred at intervals, but the patient is able to check it by resorting to the gallic acid. Since I first saw the case, twelve months ago, symptoms of deposit in the right lung have supervened.

I will now call your attention to one of the most severe cases of hæmoptysis which I have ever seen. It will serve to illustrate the principles of practice which should be adopted in the treatment of this affection.

H. B., a German, 28 years of age, described as a merchant, was admitted into the hospital under my care on the 18th September, 1868. He had just come by sea from Hamburg, and had suffered much from sea-sickness in consequence of rough weather. He told us that a year previously he had expectorated some blood, and that subsequently his health had been pretty good. I saw him soon after his admission. He was coughing up blood of a bright red colour, and in considerable quantities. His pulse was quiet, but he appeared very weak. I ordered him three grains of acetate of lead, with half a grain of opium, every four hours. I directed that he should be kept perfectly quiet, and have nothing in the way of food but small quantities of iced milk or beef-tea. I saw him on the evening of the following day. He had passed a bad night; the hemorrhage had been very profuse; the blood was almost pure, and, although I did not measure it, I am sure that many ounces had been brought up. It was kept in several vessels, and one might have thought that a series of small venesections had been practised. The pulse was 90, and the patient had taken his food pretty well. I ordered the pills to be given every two hours, and ice to be applied to the chest. On the 20th the quantity of blood expectorated was about the same as before, but the pulse had risen to 100. The patient was getting drowsy, and the pupils were contracted. I therefore stopped the opium, but continued the acetate of lead, and ordered dry cupping between the shoulders. I carefully examined the chest, but could find no marked physical signs of phthisis. There was, however, slight dulness, with deficient movement at the right apex. The heart sounds were normal. On the following day there was a slight decrease in the hemorrhage, but still the blood was in large quantities, quite fluid and florid; the narcotism had passed off, and the pulse had fallen a little. I consider that there was a *slight* improvement in the patient, but that the remedies were not acting quite satisfactorily, and that, unless the hemorrhage were soon checked, the patient would sink from exhaustion. I had given a fair trial to the acetate of lead. It had been taken for three days in frequent doses with very little effect, and I felt that some other measures should be used. I therefore ordered ten grains of gallic acid every two hours; the ice to be continued to the chest, and as much nourishment, in the shape of milk, beef-tea, and eggs, to be given as could be borne. The effect of the acid was very marked. On the 22d, when I saw the patient, after he had taken the acid for twenty-four hours, he was spitting up only little masses of blood, and the quantity was largely diminished. On the following day the improvement was still more marked, and I ordered the mixture to be taken every three hours only. On the 24th, the hemorrhage was very slight, and the pulse had fallen to 84. The gallic acid was now ordered to be taken every four hours; and on the 27th he was perfectly free from hæmoptysis, and, in fact, convalescent from his attack. But now mark what followed. On the 29th he began to get worse; the pulse rose; he became feverish; and, in fact, an attack of pneumonia of the base of the left lung set in. As I propose to refer in a special lecture to this attack of the patient, I shall say no more than that he made a good recovery from it, and was discharged from the hospital on the 23d October.

There was a very interesting case of hæmoptysis in the wards a short time ago, to which I should like to call attention.

D. C. was admitted into the hospital on the 31st January, 1870. He was 35 years of age, a cab-driver, and consequently had been much exposed to the weather; moreover, he confessed to being a free spirit-drinker. He had been in the habit, for some years, of taking five or six glasses of spirits a day. He told us that he had suffered from a cough for about two months, but that up to three days before his admission he had brought up nothing but phlegm. On the evening of January 28th he coughed up, he said, about half a pint of blood; on the following day, about a pint; and, again, on the 30th, about a pint. I saw him soon after he came to the hospital. The hemorrhage had ceased, the respiration was not hurried, and the pulse was quiet. I did not examine the chest carefully, as I did not wish to disturb him for fear of reproducing the hæmoptysis; but, from the slight examination I made, I could detect no organic disease. The man had a large pupil, a somewhat strumous aspect, and there was a flush on each cheek. The urine, on examination, was found healthy. I ordered acetate of lead and opium, and ice to the chest. For two or three days after his admission, he spat blood in small quantities; and on the 5th and 6th of February there was no hemorrhage at all; but on the 8th it returned somewhat profusely. I at once ordered him ten grains of gallic acid every four hours, and, as the hemorrhage had not quite ceased on the 10th, the medicine was given every three hours. A careful examination of the chest on that day revealed no signs of organic disease. There was good resonance on both sides, and the expansion was good. The heart sounds were normal.

For three days the man was free from hæmoptysis, and I reduced the quantity of gallic acid; but on the night of the 13th February, after reading aloud, he spat up about half a cupful of pure blood. Early on the morning of the 16th he awoke and coughed up about six ounces of blood. He continued to spit up small quantities of blood till the 19th, when there was no hæmoptysis, and the mixture was stopped, but on the following day the hemorrhage recurred to the extent of about half an ounce, and for several mornings he brought up about the same quantity. On the 24th, about 11.20 A. M., he spat up about six ounces of bright arterial blood. The gallic acid was then resumed every two hours, and ice was applied to the chest. The pulse, which had been quiet, became more frequent, 108, but it soon fell. The hemorrhage continued to a slight extent till the 27th, when it ceased, but it recurred on the 4th of March to the extent of a cupful of blood. I then added twenty minims of tincture of ergot to each dose of the gallic acid. From this time the hemorrhage gradually became less and less, and at last ceased. On the 17th he was put on tincture of iron. He had already taken cod-liver oil for about a fortnight. There was no more hemorrhage until the 30th March, on which day he brought up a little blood. I again ordered the gallic acid, and the bleeding was soon stopped. He left the hospital on the 7th April.

I made a careful examination of the chest on several occasions, and once just before the patient was discharged, but I could find no evidence of deposit in either lung, and if any existed it must have been deep-seated.

And now I will call your attention to the various measures which are usually resorted to in the treatment of hæmoptysis. In the first place, I believe that the best remedy you can use, the safest, the most rapid, and the most effectual, is gallic acid. It must be given in full doses—not less than ten grains every hour, or every two, three, or four hours; according to the severity of the case. It is readily taken by patients; it rarely disagrees with the stomach, and is well borne by delicate persons. I have now used it in a large number of cases, and I can speak with confidence of its value. I have rarely found it fail, but still it has not been invariably successful in rapidly checking the hemorrhage. You may recollect the case of Peter R——, who was so long in the house, and in whom hæmoptysis recurred over and over again. I prescribed

a variety of remedies for this man, and each in its turn failed to arrest the bleeding. It is quite true, however, that gallic acid answered better than any other agent used; it never failed to diminish the quantity of blood expectorated, and on several occasions it stopped the hæmoptysis altogether for a time, and this is more than I can say of either of the other substances used. I do not think you gain anything by giving the acid in larger doses than ten grains; but I know that some physicians give it in twenty-grain doses. It rapidly finds its way into the urine and is excreted.

Acetate of lead is another valuable preparation for arresting hæmoptysis; combined with opium it is often of great service. I usually give it in the form of pill in two- or three-grain doses every two, three, or four hours. I have seen very severe cases yield to this treatment. Some of you may recollect one of our house-surgeons who had a bad attack of hæmoptysis, and for whom I prescribed this substance, and who made a satisfactory recovery.

In the opinion of some physicians, acetate of lead is a more powerful styptic than gallic acid, but in the treatment of the form of hemorrhage which we are now considering I prefer the latter; if, however, in any case this failed, I should resort to the lead preparation. If you give it, it must be in the full doses which I have recommended.

Sulphuric acid is a good remedy in slight cases of hæmoptysis; and it may be combined with other substances, as quinia, iron, etc., which are given for the general treatment of the disease; and, indeed, I have seen cases which have been somewhat severe yield to full doses of this acid. There was a man in the wards some years ago who was spitting a good deal of blood, and for whom the house-surgeon had ordered sulphuric acid in ten-minim doses. I saw the patient for the first time after he had been taking the acid for two or three days, but it had not checked the hemorrhage in the slightest degree. I considered the dose too small, and I increased it to thirty minims. In twenty-four hours the hemorrhage had greatly diminished, and it soon stopped. If you are disposed to try this acid in any severe case, you must give it in full doses; but it is not so easily taken, nor is so well borne by patients, as gallic acid. Moreover, as it must be largely diluted to be taken, it necessitates the swallowing of a good deal of liquid, which is generally to be avoided.

Let me give you a caution in reference to the administration of opium. It is well to bear in mind its tendency to confine the bowels, for in treating persons who are very weak for hæmoptysis, you may find that when you have checked the hemorrhage you have great trouble in getting the bowels opened, and the efforts to move them may reproduce the bleeding. Of course, in any severe case you must do all you can to stop the hemorrhage, and opium, either with gallic acid or acetate of lead, is often, I think, useful. It doubtless possesses some styptic powers, and, moreover, is probably of use in sustaining the patient under the influence of the loss of blood. I advise you, however, not to continue its use longer than is absolutely necessary.

My experience of the use of ergot of rye in pulmonary hemorrhage is not very favourable. I have given the tincture in several cases, but I have not been very satisfied with the results. It may be applicable to some cases, but I do not think that it possesses such valuable properties as gallic acid or acetate of lead.

In severe cases of hæmoptysis, I always apply ice to the chest. We know that a cold substance applied to the skin will produce a reflex contraction of distant bloodvessels; and it has appeared to me that ice applied to the chest has been of service in checking hæmoptysis. I have never seen any injurious results follow its use. The ice should be applied in a bag, and should not be kept on sufficiently long to produce a chill.

You will find digitalis recommended by some writers as a valuable agent for checking hæmoptysis. I have frequently found, in cases to which I have been called in consultation, that this medicine has been given, and I know that many practitioners have great confidence in it. They do not, however, prescribe it alone, but in combi-

nation with other remedies, as sulphuric acid and laudanum, so that it is difficult to say how far the results which have followed have been due to the digitalis itself. As far as my own experience goes—and I have frequently prescribed digitalis—I cannot recommend it as a trustworthy remedy in hæmoptysis. You are probably aware that there are conflicting views in reference to the action of digitalis. On the one hand, it has been considered a cardiac sedative; on the other, a cardiac tonic. If, as is alleged by some, it have the power of causing contraction of the smaller arteries, it ought to be, theoretically, useful in hæmoptysis; but on this point I can only give you the result of my own clinical observations, and, having tried it and found it fail, I have given up its use.

I occasionally prescribe dry cupping in hæmoptysis, especially if it be of an active character; but I never fail to give styptics internally at the same time.

With regard to the administration of purgatives, I must caution you against their indiscriminate use in this affection. When you have to deal with tolerably robust individuals you may safely give purgatives, and they will often be of service; but when the hemorrhage is severe, or the patient in a very exhausted condition, you must be very careful how you further lower him by their administration. It becomes sometimes a very serious question whether the movements necessary for the action of the bowels may not prove injurious by opening a vessel which has recently closed. In some cases the thread on which life appears to hang seems so slight that we dare not allow the slightest movement on the part of the patient, and we are glad that the bowels remain inactive.

Whenever your patients show symptoms of exhaustion during the occurrence of hæmoptysis, you need not hesitate to give small doses of stimulants with food at regular intervals. I do not believe that such treatment in anywise tends to increase the hemorrhage, and it has a beneficial effect in sustaining the patient.

There is one remedy to which I have not referred; viz., turpentine. It is most valuable in hemorrhage from the bowels, but less so, in my opinion, in pulmonary hemorrhage. However, it is an agent to which you may have recourse should other measures fail.

A few words as to the general management of your patient. Let him be kept perfectly quiet, and do not allow any person to be with him except his nurse. Take care that his room is kept cool and well ventilated, and give no other food than milk and beef-tea, in small quantities and iced. Thirst will often be complained of: this is best relieved by small lumps of ice. You must not allow large draughts of iced-water, and everything likely to cause vomiting or distension of the stomach must be specially avoided. Lastly, let me advise you not to disturb your patient for the purpose of making unnecessary physical examinations.—*British Medical Journal*, March 11, 1871.

HOSPITAL NOTES AND GLEANINGS.

Hygroma of the Hyoid Bursa.—W. L., æt. 30, a carman, applied to Dr. Morell-Mackenzie at the Hospital for Diseases of the Throat, on Nov. 25, 1870, on account of difficulty of breathing and swallowing, which he attributed to a swelling just below the chin. He stated that he had first noticed the swelling about seven or eight years ago, but that it had never caused him any trouble till 1867, when he took cold, and the swelling greatly increased in size. He then consulted an eminent surgeon, who advised him to leave it alone. Subsequently, however, it caused him a great deal of inconvenience, and occasionally prevented him doing his work. The swelling had become much larger during the last year.

On examination, an ovoid tumour, about the size of a hen's egg, was found extending horizontally across the neck, and slightly attached to the hyoid membrane. The tumour was mobile, firm, and elastic. There was fluctuation on palpitation. The skin over it was healthy and non-adherent.

The case was diagnosed to be one of hygroma of the hyoid bursa, and Dr. Mackenzie directed that the cyst should be punctured, and a small seton afterwards

be put through. This was done. About three ounces of a transparent, but viscid yellowish-white fluid were drawn off. A few threads were afterwards carried through the cyst. The same evening the patient had a shivering fit, and could not sleep.

On the following morning he experienced much difficulty in swallowing, and some shortness of breath. The surface of the swelling was inflamed, and, on making a laryngoscopic examination, the epiglottis and mucous membrane of the larynx were seen to be in a state of general hyperæmia. An inhalation of the compound tincture of benzoin, and poultices over the neck were ordered.

On the 27th the bursal cyst was found to be tense, and thick laudable pus escaped from the seton openings. Dr. Mackenzie ordered one of the orifices to be slightly enlarged, and the seton removed, when a quantity of pus was poured out. This purulent discharge continued for a few days, and at the end of four weeks (December 26, 1870) the wound had healed, and the man was made an out-patient.

January 14, 1871. Finally discharged cured, there being no remains of the cyst.

Remarks.—Dr. Morell-Makenzie observed that these cases are interesting, both on account of their rarity and of the close connection which the bursa has with the larynx. A valuable communication on this subject was read before the New York Medical Association, by Dr. F. H. Hamilton, in 1869, and reported in the *Medical Record* of February, 1870. Several cases were reported by him under the name of "superlaryngeal encysted tumours," or "encysted bursal tumours in front of the larynx." On that occasion, Dr. Elsberg gave an interesting historical *résumé* of the subject. On account of their close connection with the larynx, any curative treatment of these tumours is likely to give rise to laryngitis. The plan commonly adopted consists in puncturing and injecting iodine; but this treatment is not so certain as that by seton, for the cyst not unfrequently fills again. All observers who have met with these cases are agreed that all attempts at extirpation would be met with considerable danger. In addition to the hyoid bursa, subcutaneous bursal cysts are sometimes found over the thyroid, and even as low as the cricoid cartilage.—*Med. Times and Gaz.*, Feb. 11, 1871.

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Colotomy and Operation for Fecal Fistula.—Mr. Christopher Heath, on Feb. 4th, at the Hospital for Women, Soho-Square, performed colotomy for malignant disease of the rectum. While the patient was being brought under the influence of chloroform, Mr. Heath explained that the patient had only on the night before come into the hospital. There had been a scirrhous condition of the rectum for a long time, the disease being situated three inches from the anus, and being attended by the usual symptoms of painful defecation, and occasional losses of blood. Mr. Heath had long since advised colotomy, but the patient refused, and it was only two days ago, when, absolute obstruction having been present for a week, stercoraceous vomiting had already set in, that Mr. Heath was sent for, and the woman submitted to the operation. Mr. Heath referred to a similar operation performed by him on the previous Saturday, in which, however, the conditions were more pleasant, as the state of the lower bowel rendered it possible to distend the colon with water, and so render it easily and cleanly reached. Here, probably, also, the bowel would be distended, but with feces, which would make the operation of a more disgusting character. Before making his incision, Mr. Heath marked with ink, on the left loin, a vertical line, half an inch behind the midpoint of the crest of the ilium, which, he said, was an infallible guide to the colon. He then dissected straight down on this line, at once exposed the distended colon, and before opening it, passed two sutures through the bowel and skin, keeping them loose, but attached on either side to the edge of the wound. Then, the gut being drawn up and opened, the middle of each thread was pulled up, cut, and the opened bowel at once stitched to the lips of the wound without further trouble. There was an immediate escape of feces, and as this subsided, a quantity of pulled

oakum was packed over the wound, and the patient returned to bed. By this method of procedure, the operation was conducted with a precision, rapidity, and cleanliness which we have not before witnessed.—*Medical Times and Gazette*, March 4, 1871.

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Case of Tetanus Neonatorum treated with Chloral Hydrate; Recovery.—Dr. WIDERHOFER showed lately to his class at the Children's Hospital, Vienna, a child of three months old, which was attacked by tetanus neonatorum at the end of the first week after birth, and was treated with chloral hydrate in doses of one and two grains at the time of each onset of convulsions. It was in danger for a fortnight. During the intermission of the spasms it was fed from the breast by its mother. It is now a fine, healthy-looking child. This is the sixth case (out of ten or twelve) that Dr. Widerhofer has had of recovery under treatment by chloral. Under all other methods all his previous cases died. Considering that Vogel, and other great German authorities on children's diseases, had quite recently never seen a case of this affection recover, such a success must be taken to indicate a real advance in therapeutics. Dr. Widerhofer gives from two- to four-grain doses of chloral by the rectum, if the infant cannot take it by the mouth.—*Lancet*, March 18, 1871.

MEDICAL NEWS.

DOMESTIC INTELLIGENCE.

Treatment of Gonorrhœa by Warm Water Injections.—Dr. JOHN O'REILLY contributes a short article on this subject to the *American Practitioner* (April, 1871). The conclusions at which he arrives are the following:—

1. That gonorrhœa yields to local treatment, and even water injections.

2. That water injections or medicated lotions owe their efficiency to their frequent application.

3. That the common small syringe should be done away with in treating this disease, and none used but those throwing a continuous stream.

4. That large injections, by fully distending the mucous membrane of the urethra, insure a speedier cure than those less copious.

This method of treatment Dr. O'Reilly instituted in the Venereal Hospital established at Nashville in connection with the army of the Cumberland. The patients were ordered the usual diet of the hospital, with no drinks but water, and the nurse was directed to inject freely tepid water into the urethra every hour, except at night, during which period the patients were instructed, if they awoke, to use the injection themselves. The result was that in five days the patients were pronounced well, the discharge having ceased in forty-eight hours after the treatment was commenced.

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The Pennsylvania Hospital.—The No. of the *Medical Times* for April 15, 1871, contains a sensible article respecting this useful and venerable institution. Our contemporary justly states that "there is no other institution in Philadelphia in which the interests of the medical profession have centred for so long a time as" in it. From 1766 down to the present time, a period of upwards of a century, clinical lectures have been given there.

"The prosperity of Philadelphia as a seat of medical teaching has been largely owing to the excellence of the clinical instruction given at the hospital, and the graduates of her schools have always recalled with pleasure the time spent within its walls. With such pleasant recollections of its greatness, we cannot look with equanimity or indifference upon its present decline in popularity with students.

"In the early part of November, 1869, nearly five hundred tickets were sold, and we are told that on one or two occasions that number of students actually assembled in its amphitheatre—constituting, it is believed, the largest class in attendance upon clinical lectures in the world. During the past winter less than two hundred students attended the clinics. Why has this change occurred? More favourably situated than any other hospital in the city, within ten minutes' walk of the two great schools of medicine and

of the homes or boarding-houses of the students, with precisely the same medical staff, many of the members of which are popular teachers, and affording opportunities for clinical study unsurpassed elsewhere, the change since last year seems incomprehensible.

"We can only regard it as one of the results of the action of the contributors to the hospital, who, at their last annual meeting in May, practically decided that the medical staff, comprising the only officers of the hospital who are at all fitted to decide questions pertaining to medical teaching, should have no voice in determining them."

If the contributors to the hospital desire to restore the former renown of the institution, they should in its management defer more than they have latterly done to the judgment of their medical staff, as was formerly the case in the palmy days of Morgan, Rush, Physick, Wistar, and their contemporaries. Indeed it was a great mistake in the original organization of the hospital that its medical staff were not given a vote in its management. They should be *ex officio* members of the Board of Managers, for it must be evident that in all matters, except merely those of finance, they are more competent, from their education and training, to decide what is best for the interest of the sick and the advantage of the institution as an educational one than can be gentlemen brought up to mercantile pursuits.

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South Carolina Medical Association.—This association held its annual meeting in the city of Charleston on the 4th, 5th, and 6th of April last. Several interesting papers were read, and the following officers were elected for the ensuing year:—

F. Peyre Porcher, M.D., Charleston, President; R. W. Gibbes, M.D., Columbia, First Vice-President; A. P. Wylie, M.D., Chester, Second Vice-President; D. S. Price, M.D., Marion, Third Vice-President; T. Grange Simons, M.D., Charleston, Recording Secretary, *vice* J. S. Buist, declined re-election; S. Baruch, M.D., Camden, Corresponding Secretary, *vice* F. P. Porcher, elected President; F. L. Parker, M.D., Charleston, Treasurer.

After the transaction of other important business the association adjourned to meet in Columbia on the third Tuesday in April, 1872.

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Medical and Surgical Memoirs.—Joseph Jones, M.D., Professor of Chemistry, Medical Department, University of Louisiana, is preparing for the press a work embracing his investigations during fifteen years into the Causes, Geographical Distribution, Natural History, and Treatment of Intermittent, Remittent, and Congestive Malarial Fevers, Yellow Fever, Typhoid and Typhus Fevers, Smallpox, Spurious Vaccination, Measles, Pneumonia, Diarrhœa, Dysentery, Scurvy, Tetanus, Cerebro-spinal Meningitis, Diseases supervening upon Gunshot Wounds, Pyæmia, Hospital Gangrene, Erysipelas, etc. The work will be published as soon as a sufficient number of subscribers have been obtained

Those desiring to become subscribers should forward their names to Joseph Jones, M.D., Glass Box 1542, New Orleans, La.

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Obituary Record.—It is with regret that we record the death at Cincinnati, Ohio, on the 22d of March last, at the mature age of 76, of Dr. W. T. Talaferro, formerly of Maysville, Kentucky, but for a number of years past a resident of Cincinnati. He was a skilful ophthalmologist and highly estimable gentleman.

FOREIGN INTELLIGENCE.

Therapeutic Value of Iodine in the Treatment of Syphilis.—Mr. Berkeley Hill, of the Male Lock Hospital, considers it of first importance, in estimating the power of iodine to subdue syphilis, to determine the stage during which the drug is most serviceable, and what are the forms in which the disease betrays itself during that stage.

Iodine is, he says, unquestionably of high value in all the skin affections characterized by prominent or deeply-set tubercles in the skin, and those marked by ulceration rather than by desquamation. In the visceral forms of syphilis

also, in periosteal and osteal affections, and in muscular tumours, the extreme value of iodine is beyond doubt. This indisputable effect of iodine in certain forms, and the prejudice against mercury, have led many practitioners to employ iodine for all the phenomena of syphilis. This Mr. Hill believes to be a mistake, for two reasons. The first: that he has never been able to trace any result from the exhibition of iodine either for the initial sore or for the roseolous and papulo-scaly eruptions on the skin. Undoubtedly, these symptoms may disappear while iodine is being taken; but it has not yet been shown that they do so with greater rapidity than when the patient is subjected to no specific treatment whatever. The second: that he is strongly convinced that the earlier the disease is controlled, the more likely is the patient to escape a tedious course and the dangerous sequelæ of syphilis. Consequently, he regards the iodine treatment of early syphilis as a loss of valuable time, and as an exposure of the patient to the chance of ultimate, and possibly avoidable, suffering. The converse is, however, unfortunately not always true: the best and most careful treatment of syphilis at the outset is not a perfect safeguard against a severe course of the malady. Nevertheless, every year increases his confidence in the protective value of a judicious early treatment.

Mr. Hill believes that iodine is generally given with advantage to feeble persons, whose eruption is pustular rather than bullar; but even here he thinks it possible that the stimulant effect of iodine is the chief benefit derived from the drug, and mercury should follow the iodine as soon as the restored vigour of the patient will allow; and if, in such cases, iodine alone is relied on, the disease commonly recurs in the same or some other form. Iodine, therefore, he considers useless in all initial sores, and in early scaly or muscular eruptions, but often serviceable as a preliminary to mercurial treatment for debilitated persons.

But even when unquestionably appropriate, it should always be followed by mercury. When the patient is apparently restored to health, he should at once begin a course of small doses of mercury, given continuously, or with occasional short intervals of iodine, and lasting four or even six months. The dose of mercury need not be sufficient to produce any soreness of the gums; slight sponginess is all that is needed. A fifth or a fourth of a grain of perchloride in the twenty-four hours, given with cinchona solution and hydrochloric acid, is very effectual. Ammonia should not be used in any form with the mercury, for it has been shown by Mr. Martindale, teacher of practical pharmacy and dispenser in University College Hospital, that the perchloride, when mixed with ammoniacal salts, is gradually but completely precipitated from solution as ammonio-chloride; hence, though this precipitate would be dissolved in the stomach and produce its proper effect, the chance of its remaining as sediment at the bottom of the bottle renders ammoniacal solutions of mercury uncertain and unfit for internal use. Simple distilled water dissolves the perchloride quite sufficiently for this purpose.

Iodine is also useful, when given after a mercurial course, to prolong the influence of mercury which has been given early in the disease. In such cases it will frequently control even scaly eruptions, which otherwise would be slow to subside. This effect has been attributed to the fact of the mercury, which has been deposited in the tissues, being redissolved into the circulating fluids.

The modes of giving iodine vary much with the individual. Small doses of two or three grains, three or four times daily, should be combined with some aromatic or astringent tincture or infusion to prevent the irritation of the alimentary canal that sometimes occurs. But these small doses soon lose their effect, and must be gradually increased by about one-third at successive steps. This rule holds good also for large doses. If a patient ceases to derive benefit from twenty grains, the increase should at once be made to thirty, for a smaller addition to the dose seldom has any effect. The augmentation should be continued until the disease has disappeared, or until symptoms of iodism show that no more can be borne. In the latter

event the use of iodide should at once be discontinued for a short time, and subsequently resumed in some other form. For example, if iodide of potassium has been previously used, the sodic or ammoniac iodide should be tried, and that in half the former dose. Sometimes it happens, after taking long courses of iodide of potassium, that the stomach grows intolerant of the alkali, the tongue becomes white and furred, the stomach loathes food, and the syphilitic symptoms cease to show any abatement. This condition is often not comprehended by practitioners, who abandon the iodide (or are themselves abandoned by the patient), and take to mercury or some other drug, which in such a state of the alimentary canal can command no success. A dose of blue-pill and colocynth, with a few days' treatment with nitro-hydrochloric acid, and complete abstinence from alcoholic drink, will, however, speedily restore the appetite, clear the tongue, and render the patient again able to take the iodide. Mr. Hill has known a disordered stomach to make iodine inoperative, even when that drug had been taken for only a short time. In one case he was applied to by a medical man for advice about a very painful node on which iodide of potassium produced no effect. He found that the stomach was considerably deranged, and prescribed some simple remedy for its condition before making a further attempt with the iodide. Then, on the iodide being resumed, the patient was immediately relieved of the pain and swelling, which it had before failed to influence. Again, the use of iodine can sometimes be prolonged, after the system has tired of it, if combined with sarsaparilla, of which the most useful forms are, in Mr. Hill's opinion, the liquid extracts of Bell or Squire. One, two, or even three drachms should be given in half a pint of water, with the requisite dose of iodide, about midway between, or two hours after, meals. Ammonia very greatly assists the effect of iodide of potash in debilitated patients. It is a more valuable adjunct than the salts of iron even. Four or five grains of the sesquicarbonate may be added to the draught of iodide. Bromide of ammonium added to the iodide has apparently also a good effect in the nervous affections of syphilis. With regard to the form of iodide to be employed, the salts of potassium, sodium, and ammonium alone can be trusted to produce marked effects of iodine; but which of these is preferable Mr. Hill hesitates to decide. The taste of each of them is, perhaps, equally disagreeable; but the sodic and ammoniac forms, having smaller equivalents of alkali, furnish a larger amount of iodine, weight for weight, than the potassic. Empirically, he has not been able to detect any particular advantage in any one of these salts over the others. Either of them, if pushed too far, will produce iodism; and the same patient will at one time bear one better than another. He has not been able to detect any difference between the effects of these three salts, except that each is useful for ringing a change in cases where the use of iodine must be long continued.

The toxicological effects of iodine are various. That most commonly complained of is irritation of acne pustules in persons subject to that complaint. The appearance of this symptom always indicates a short course of acids; so do the dry, red tongue so well described by Mr. L. Parker, coryza, and the other decided signs of iodism. Flat papules and flat pustules of the skin are so rarely produced that they should never be waited for as a sign that iodine has been pushed too far. Nevertheless, Mr. Hill has seen them produced on two occasions when very few grains of iodide had been taken. The subjects belonged to a rare class, which appears to be constitutionally unable to take iodine in any form.—*Lancet*, March 4, 1871.

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Treatment of Palpitation of the Heart.—Dr. Fred. B. Nunnely states (*Lancet*, Feb. 25, 1871) that of all remedies, he has found the subcutaneous injection of morphia to be the most trustworthy; it nearly always alleviates, and very frequently cures, the complaint after a few repetitions. One-twelfth to one-tenth of a grain is a sufficient dose to begin with, and there is little occasion to exceed this quantity. The injection should be re-

peated every third or fourth day. Though the arm is the most convenient place to insert the needle, the injection is sometimes more effectual at the præcordia. When morphia fails, or is not tolerated, atropia may be substituted; but is not, I think, so useful. If the prick is objected to, the morphia may be applied to the derma denuded by a small blister raised with ammonia, as Trousseau recommends. The hypodermic application of morphia has the additional advantage of relieving pain.

Local applications are of great service. Belladonna and its preparations stand in the first rank of these. The ordinary belladonna plaster, of good size and renewed every week or ten days, is very convenient and effective. It presents three special advantages: it protects the chest walls, which are tender, from the pressure of the clothes, and seems to deaden the painful impulse of the heart; besides this, it impedes slightly the free movement of the parts, and thus obviates the muscular pain often present. Another good application is a mixture of equal parts of liniment of belladonna and of liniment of chloroform, sprinkled on cotton-wool. Hot linseed and mustard poultices are soothing, and are easily obtained.

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Gastric Juice Enemata in Cancer of the Rectum.—Dr. D'Arpem, of Elba, has reported (*Lancet*, March 18, 1871, from *Imparziale* of Florence, March 1, 1871) a case illustrating the marvellous effects of this juice in cancer. The patient is a married woman, aged thirty-eight, who suffered, according to the author's diagnosis, from carcinomatous ulceration of the rectum and cervix uteri. After having controlled the uterine hemorrhage with perchloride of iron, Dr. D'Arpem was in doubt as to the treatment of the malignant ulceration, when he heard of the views of Professor Schiff on the subject. The latter had for some time advocated the use of gastric and pancreatic juice in cancer.

Being applied to, the professor furnished the author with artificial gastric juice, and advised injections into the rectum of about seven fluidrachms of the juice daily. Much pain was experienced from the first injection, but this was lessened by the use of some almond oil. The seven drachms were now divided into three parts, injected separately three times a day. This was continued for twenty days, when considerable improvement had taken place, both as regards the rectum and the womb. The patient was now so well as to be able to perform a journey with her husband, and on her return the cicatrization of the ulcer was complete. She had continued the enemata at longer intervals during her absence, and she now presented all the outward signs of health. Such are the facts related by the author. If the diagnosis were perfectly reliable, we might harbour the hope that the specific for cancer has been found. But the case is isolated, and does not present the proper guarantees as to diagnosis. Nor is it likely that numerous trials will be made in the same direction.

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Chloral Hydrate.—Dr. Richardson, in one of his recent lectures on experimental and practical medicine (*Lancet*, Feb. 11, 1871), made the following interesting observations on chloral hydrate, in reply to questions that are continually presenting themselves to the mind of the practitioner.

What is a dangerous and what is a fatal dose of hydrate of chloral? The largest dose I have known to be taken is one hundred and twenty grains. This dose produced a prolonged and dangerous coma, but recovery ultimately followed. I think we may consider a hundred and twenty grains, as a maximum dose for an adult, dangerous, but not of necessity fatal. Beyond a hundred and twenty grains the danger increases, and a hundred and eighty grains may be considered a dose that would prove, in the majority of cases, positively fatal.

What quantity of hydrate of chloral can be given with safety in divided doses during a stated period of time, say of twenty-four hours? Judging from the physiological effects of hydrate of chloral in relation to dose, and to order of phenomena in relation to time, I should infer that the body cannot decompose and throw off the hydrate more rapidly than at the rate of

from five to seven grains per hour. There will be difference according to age of person, the temperature to which the body is exposed after the dose has been taken, and the largeness of the dose, a small dose being disposed of quicker in proportion than a large one. But the variation is not such as to alter materially the rate of action from the estimate given. I should consider, consequently, that a hundred and twenty grains, administered, even in divided doses, in twenty-four hours, would be the safe limit of administration. In the treatment of tetanus this proportion has been exceeded, but not, I think, to the safety of the patient; for the fact that the hydrate of chloral overcomes or reduces the spasm is no safeguard against its own poisonous effects. From what I know, I conclude that the hydrate of chloral can be given to the extent of overcoming the severest spasm; but if the dose be carried too far, with the determination of removing spasm at all risks, the success may easily be bought at the expense of a fatal narcotism from the remedy.

Does the frequent administration of hydrate of chloral lessen or increase the danger of the administration? On this question I am forced to state that the frequent administration of the hydrate of chloral, though it may suggest greater confidence in it on the part of those who take it, increases the danger from an excessive dose. Hydrate of chloral differs from opium in this respect, opium produces chronic symptoms peculiar to itself, but the dose may be steadily increased without any immediate danger from the increase. Hydrate of chloral cannot be used in this accumulative way without danger. In a word, although a person may become habituated to hydrate of chloral, there is a limitation of the quantity to be taken safely, which limitation is not materially modified by persistence in the habit of taking it, but rather the reverse.

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Death from Hydrate of Chloral.—Dr. H. W. Fuller reports (*Lancet*, March 25, 1871) a case in which thirty grains of chloral twice produced alarming symptoms, and another in which the same dose caused death.

He concludes: Judging from what I have learned from various members of our profession, I believe that although fatal consequences may rarely follow a dose of thirty grains of the chloral hydrate, yet that unpleasant, if not dangerous, symptoms are not unfrequently experienced. Dr. Tuke informs me that in a man whom he saw suffering from the effects of intemperance thirty grains very nearly proved fatal, the symptoms of depression and failure of the heart's action being most alarming; and Mr. Fred. Webb, of Maida-vale, has given me the particulars of another case in which an elderly man very nearly lost his life from the effects of thirty grains. The faintness, pallor, and depression of the heart's action were excessive, and for some time Mr. Webb was in doubt whether he would be able to sustain the pulsations of the heart until the effects of the chloral had passed.

Doubtless these cases are quite exceptional, and are met with only in about the same proportion as cases of death from the administration of chloroform. But the facts I have cited are sufficient to prove that such cases are more frequent than is commonly supposed. Further, they inculcate the necessity for caution in the administration of the drug; and they point to the conclusion that thirty grains form too large a dose for ordinary use, and especially for a patient in whom the effects of chloral have not been previously tried. As a hypnotic in nervous restlessness, ten or fifteen grains ordinarily prove efficacious; and I have not seen or heard of any unpleasant symptoms following these doses. But the cases above recorded prove that larger doses, though usually harmless and often marvellously efficacious, are not unattended with risk; and now that the public are beginning to dose themselves with chloral, as they have done of late years with chlorodyne, this important fact cannot be too widely known.

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Metachloral.—Dr. Richardson exhibited to the Medical Society of London (March 18) this substance. It is a white powder, insoluble in water and alcohol. It is believed by Dr. Richardson, from experiments made on the lower animals, to

possess mild narcotic properties. Metachloral is isomeric with chloral. It is produced when chloral hydrate is brought into contact with sulphuric acid. Chloral, also, may be changed into metachloral spontaneously when it is kept for a long time in a stoppered bottle, or when a quantity of water insufficient to produce the hydrate is added to it. Heat converts metachloral into the liquid chloral, which becomes the hydrate on the addition of a sufficient quantity of water. Owing to its affinity for water, chloral is a caustic, and Dr. Richardson thinks that this fact, taken together with that of its after soothing effects, may be turned hereafter to practical value. The specimen of metachloral exhibited by Dr. Richardson was prepared by Dr. Versmann by bringing chloral hydrate in contact with sulphuric acid at 140° Fahr. By treating it with alkalies, metachloral yields a formate and chloroform.—*Med. Times and Gaz.*, March 18, 1871.

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Deaths from Chloroform.—A patient had been admitted into the Royal Infirmary of Edinburgh for dislocation of the hip, which was being reduced when the fatal occurrence took place. At the post-mortem no organic lesion was discovered. —*British Medical Journal*, March 11, 1871.

In the *British Medical Journal* (March 25, 1871) is recorded the case of a man who was operated upon for fistula. About one drachm and a half of chloroform was administered on a cone of lint; during the operation the breathing and pulse suddenly ceased. All the organs of the body were found to be healthy, excepting that there was an immense amount of fat.

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Smallpox and its Prevention.—Dr. CRISP read before the Medical Society of London, at a late meeting, a paper on the above subject, which at this time is especially valuable and interesting. The subjoined are some of the conclusions arrived at by the author: That no deleterious effect is produced upon the human constitution by the introduction of cow-pox matter—an inference greatly strengthened by the fact that, since the introduction of vaccination, the population of the United Kingdom has nearly doubled. That government hospitals should be established in the metropolis, in suitable localities, and provided with proper vehicles for the conveyance of patients, and with proper heat-chambers for disinfection. That, looking to the important fact that in ten years—1851 to 1860—42,071 deaths occurred in England and Wales from smallpox, and that 37,007 of these deaths were in young persons under 13 years of age, the recommendation given by the Privy Council and by the London College of Physicians should not be followed, but that where there is danger of infection, children of all ages should be revaccinated. That there is no sufficient reason why lymph, during the time of an epidemic, when it is often difficult to procure, should not be taken from adult persons, provided they are free from disease and the vesicle presents a normal appearance. That more extended observations are needed before we can come to the conclusion that the amount of exemption from smallpox depends upon the number of marks upon the arms from previous vaccination.

The general opinion in the profession is distinctly opposed to the use of revaccination lymph at all, and the rule that hence has arisen is one which should generally be observed. Still there is no scientific reason why revaccination lymph should not be availed of occasionally under the conditions mentioned by Dr. Crisp—viz: 1. During an epidemic season (when, by the way, revaccination appears to be unusually successful). 2. When primary lymph cannot be procured. 3. When the vaccinifer is absolutely free from disease or constitutional taint. 4. (Most emphatically) When the revaccination vesicle exhibits in its course and appearance all the characters of a normal primary vesicle. 5. On condition that the lymph be taken about the sixth day, or before there is a trace of areola.—*Med. Times and Gaz.*, March 11, 1871.

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Efficacy of Revaccination.—Dr. CARPENTER, of Croydon, at a recent meeting of the local Board of Health stated that at the recent outbreak of smallpox at St. George's

Hospital, where seventeen cases occurred by contagion from a case accidentally admitted, and fourteen days after its removal, every servant, nurse, medical man, and student connected with the establishment was immediately vaccinated, and although the seventeen patients were treated in the hospital, not a single case occurred afterwards.

Again, that in his own private practice, and that of other medical gentlemen in Croydon, who being careful that their whole *clientile* were properly vaccinated, had not had a single person fall a victim to the disease.—*Med. Times and Gazette*, April 8, 1871.

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Heifer Vaccination.—It is stated (*Med. Times and Gazette*, April 1, 1871) that no one of any authority, that we know of, has advocated the substitution of heifer vaccination for vaccination from arm to arm in this country [Great Britain].

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Smallpox in India.—Dr. De Renzy, Sanitary Commissioner of Punjab, states that in that province, with a population of 5,000,000, the deaths from smallpox are never less than 20,000 a year. In 1869, they numbered 53,195. Contrast these terrible totals with the smallpox mortality of England, in which, with its population of 21,000,000, the average of smallpox deaths does not now exceed 5000 a year, though previously to the introduction of vaccination it was quite as high as it is now in the Punjab. But it is not merely in the saving of life that the benefit of vaccination consists. The amount of physical disfigurement caused by smallpox in the Punjab is enormous. Any person walking through the streets of a Punjab city is struck by the immense proportion of persons blind of one or both eyes—a calamity caused, in ninety-nine cases out of a hundred, by smallpox. Europeans, who, as a rule, are tolerably well protected by vaccination, suffer very little, though they live in the midst of a never-ending epidemic; and natives have everywhere remarked the immunity of Europeans from the injuries to the eyes and other disfigurements to which they are themselves so subject.—*British Medical Journal*, April 8, 1871.

Fibrous Tumour of Heart.—Mr. Wagstaffe presented to the Pathological Society of London an exceedingly rare specimen of probable fibrous tumour of the heart, which occurred in the practice of the late Mr. Nunn, of Lyndhurst. It was removed from the body of a child three months old. The child was quite healthy until a few weeks before its death, when it had occasional transitory spasms, in one of which it died suddenly. The tumour was situated in the substance of the septum ventriculorum. Microscopically, it appeared to be mainly composed of well-developed white fibrous tissue. Mr. Wagstaffe said there was only one case on record in the *Transactions* of the Society of a true simple tumour of the heart, and that was of a peculiar cystic form. He considered the specimen, therefore, unique. Its occurrence in a child three months old without interference with nutrition, and with such slight symptoms, made it a case of extreme clinical interest.—*Brit. Med. Journ.*, Mar. 11, 1871.

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Obituary Record.—We learn from the *British Medical Journal* (March 25, 1871) that among the victims whom the medical profession has furnished in connection with the recent Franco-German war, have been two men of more than common note—Professor Albrecht Wagner of Königsberg, who died at Dole on February 15th; and Professor Felix von Niemeyer of Tübingen, who has died lately at Nancy. The cause of death in both cases was typhoid fever, contracted in the discharge of duty. Dr. Wagner was well and favourably known in Germany for his works on the Resection and Regeneration of Bones (translated a few years ago by the New Sydenham Society), on Hydrophobia, Diabetes in connection with Carbuncle, Resection of Nerves, etc. Dr. Wagner had been attached to the army of General von Manteuffel as surgeon-general. The name of Dr. Felix von Niemeyer has become well known among us through the translations of his excellent *Text-Book of Practical Medicine* and his *Lectures on Phthisis*. He was Director of the Field Ambulance at Nancy. In the deaths of Wagner and Niemeyer, a great loss has indeed been sustained by medical science.

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It satisfies a want which must have been sorely felt by the busy general practitioners of this country. It takes the form of a manual of clinical description of the various forms of insanity, with a description of the mode of examining persons suspected of insanity. We call particular attention to this feature of the book, as giving it a unique value to the general practitioner. If we pass from theoretical considerations to descriptions of the varieties of insanity as actually seen in practice and the appropriate treatment for them, we find in Dr. Blandford's work a considerable advance over previous writings on the subject. His pictures of the various forms of mental disease are so clear and good that no reader can fail to be struck with their superiority to those given in ordinary manuals in the English language or (so far as our own reading extends) in any other.—*London Practitioner*, Feb. 1871.

Dr. Blandford's book well meets the prevailing deficiency, and is one of that class, unhappily too small, which prove a real blessing to the busy practitioner who has no other time for reading but those odd moments which he can catch in his brief intervals of leisure. It is so free from defects and is so fair a representation of the most approved views respecting insanity, that we find in it small occasion for criticism, and can do little more than commend it as an admirable manual for practical use. We end as we began, in heartily recommending it as a most useful and reliable guide to the general practitioner.—*Am. Journal Med. Sciences*, April, 1871.

HENRY C. LEA, Philadelphia.